**MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS**
**DIVISION OF WORKERS' COMPENSATION**

| | | |
|---|---|---|
| _____ | ) | |
| HEALTH CARE PROVIDER | ) | IN RE: Medical Fee Dispute No: _____ |
| | ) | |
| vs. | ) | Employee (Patient): _____ |
| | ) | |
| _____ | ) | Employee (Patient) Social Security No: _____ |
| EMPLOYER | ) | |
| | ) | Date of Accident/Incident: _____ |
| _____ | ) | |
| INSURER | ) | Workers' Comp Injury No: _____ |

REQUEST FOR DISMISSAL OF NOTICE OF SERVICES PROVIDED
REQUEST FOR DIRECT PAYMENT

The undersigned party hereby requests that the Division of Workers' Compensation of the State of Missouri dismiss its application entitled Notice of Services Provided & Request for Direct Payment on the following grounds:

☐ The medical fee dispute has been resolved or otherwise compromised and settled.
Date _____ Amount _____

☐ The dispute does not involve the type of medical fee dispute applicable to the administrative process involved in the filing of an Application for Notice of Services Provided & Request for Direct Payment.

☐ The health care provided by the undersigned was not authorized by the employer or insurer.

_____
Health Care Provider

_____
Health Care Provider's Attorney

_____
Address and Telephone

Date: _____

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and accurate copy of the Request for Dismissal of Notice of Services Provided & Request for Direct Payment has been mailed by first-class mail, postage prepaid or hand delivered to _____ (name and address of opposing party or opposing party's attorney) this _____ day of _____ , 20____.

_____
Petitioner or Petitioner's Attorney